painting as Improvements. Providers may not report such expenditures as prepaid expenses.

5. Laundry Expense. Providers must separately identify the expense associated with laundry services for which non-Publicly-Aided Residents are billed. Providers must identify such expense as non-related to Medicaid patient care.

6. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as Other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.

7. Nursing Costs. The costs must be associated with direct resident care personnel and be required to meet federal and state laws.

8. Related Parties. Providers must disclose salary expense paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services.

(f) Special Cost Reporting Requirements.

1. Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider may not identify expenses of such programs as related to the care of Massachusetts publicly-aided Residents.

a. If the Provider converts a portion of the Provider to another program, the Provider must identify the existing Equipment no longer used in Nursing Provider operations and remove such Equipment from the Nursing Provider records.

b. The Provider must identify the total square footage of the existing Building, the square footage associated with the program, and the Equipment associated with the program.

c. The Provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The Provider must directly assign to the program any additional capital expenditures associated with the program.

2. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Provider must file Cost Reports on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 Hospital Cost Report. The Provider must:

a. identify the existing Building and Improvement costs associated with the Nursing Provider. The Provider must allocate such costs on a square footage basis.

b. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the Provider must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 6.02. The Provider may elect to report major moveable and fixed Equipment by one of two methods:

1. A Provider may elect to specifically identify the major moveable and fixed Equipment directly related to the care of Publicly-Aided Residents in the Nursing Provider. The Provider must maintain complete documentation in a fixed asset ledger, which clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Division with its first Notification of Change in Beds.

2. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment , the Division will allocate fixed Equipment on a square footage basis.

c. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Provider within the hospital as Additions. The Division will allocate capital expenditures which relate to the total plant on a square footage basis.

d. The Provider must use direct costing whenever possible to obtain operating expenses associated with the Nursing Provider. The Provider must allocate all costs shared by the hospital and the Nursing Provider using the statistics specified in the Hospital Cost Report instructions. The Provider must disclose all analysis, allocations and statistics utilized in preparing the Nursing Provider Cost Report.

(2) General Cost Principles. In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

(a) The cost must be ordinary, necessary and directly related to the care of Publicly-Aided Residents;

(b) The cost must be for goods or services actually provided in the nursing facility; and

(c) The cost must be reasonable; and

(d) The cost must actually be paid by the Provider. Costs which are not considered related to the care of Massachusetts publicly-aided Residents include, but are not limited to: costs which are discharged in bankruptcy; costs which are forgiven; costs which are converted to a promissory note; and accruals of self-insured costs which are based on actuarial estimates;

(e) A provider may not report the following costs as related to the care of Massachusetts publicly-aided Residents:

1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;

2 Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;

3. Expenses that are not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;

4. Compensation and fringe benefits of residents on a Provider's payroll;

5. Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;

6. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;

7. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies that are not registered with the Department under regulation 105 CMR 157.000;

8. Any expense or amortization of a capitalized cost which relates to costs or expenses incurred prior to the opening of the facility;

9. All legal expenses; and those accounting expenses and filing fees associated with any appeal process.

(5) Filing Deadlines.

(a) General. Except as provided below, Providers must file required Cost Reports for the calendar year by 5:00 P.M. of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

1. Change of Ownership. The transferor must file Cost Reports within 60 days after a Change of Ownership. The Division will notify the Division of Medical Assistance if required reports are not timely filed for appropriate action by that agency.
2. New Facilities and Facilities with Major Additions. New Facilities and facilities with Major Additions that become operational during the Rate Year must file year end Cost Reports within 60 days after the close of the first two calendar years of operation.
3. Hospital-Based Nursing Facilities. Hospital-Based Nursing Facilities must file Cost Reports no later than 90 days after the close of the hospital's fiscal year.
4. Termination of Provider Contract. If a Provider contract between the Provider and the Division of Medical Assistance is terminated, the Provider must file Cost Reports covering the current reporting period or portion thereof covered by the contract within 60 days of termination.
5. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, s. 72N, the Provider must file Cost Reports for the current reporting period or portion thereof, within 60 of the receiver's appointment.

(b) Extension of Filing Date. The Director of the ACE Group may grant a request for an extension of the filing due date for a maximum of 45 calendar days. In order to receive an extension, the Provider must:

1. submit the request itself, and not by agent or other representative;
2. demonstrate exceptional circumstances which prevent the Provider from meeting the deadline; and
3. file the request no later than 30 calendar days before the due date.

(6) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of receipt. The Division will specify the additional information which the Provider must submit to complete the Cost Reports. The Provider must file the required information within 25 days of the date of notification or by April 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and will be deemed to be filed on the date of receipt.

(7) Audits. The Division and the Division of Medical Assistance may conduct Desk Audits or Field Audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any Related Party as requested during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports.

(8) Penalties

(a) If a Provider does not file the required Cost Reports by the due date, the Division will reduce the Provider's rates for current services by 5% on the day following the date the submission is due and 5% for each month of non-compliance thereafter. The reduction accrues cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late and so on. The rate will be restored effective on the date the Cost Report is filed.

(b) If a Provider has not filed its Cost Report by six months after the due date, the Division will notify the Provider thirty days in advance that it may terminate the Provider's rates for current services. The Division will rescind termination on the date that the Provider files the required report.

6.08 Special Provisions

(1) Rate Filings. The Division will file certified rates of payment for Nursing Facilities with the Secretary of the Commonwealth.

(2) Appeals. A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after the Division files the rate with the State Secretary The Division may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal .

(3) Information Bulletins. The Division may issue administrative information bulletins to clarify provisions of 114.2 CMR 6.00 which shall be deemed to be incorporated in the provisions of 114.2 CMR 6.00. The Division will file the bulletins with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during regular business hours.

(4) Severability. The provisions of 114.2 CMR 6.00 are severable. If any provision of 114.2 CMR 6.00 or the application of any provision of 114.2 CMR 6.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 114.2 CMR 6.00 or the application of any other provision.

REGULATORY AUTHORITY

114.2 CMR 6.00: M.G.L. c. 118G.

Appendix B

The attached amendment to 114.2 CMR 6.06(1)(d) was proposed on February 2, 2001 and was effective as of February 16, 2001. The public hearing was held March 13, 2001 and the regulation will be approved as of April 3, 2001.

The amendment does not alter methods or standards of calculating reimbursement; and therefore has no fiscal impact.

as proposed 2/2/01

(d) Certified Nursing Assistant Add-on Recovery.

1. Permissible uses of CNA add-on revenue. Providers must use the add-on revenue solely to increase base hourly wages and payroll taxes for Certified Nursing Assistants. Such revenue may not be spent on overtime or additional CNA hours. In the following calculations (1) CNA hours and CNA wages exclude overtime or non-permissible bonuses and (2) the term "average hourly wages" includes wages and payroll taxes. A portion of revenue may be used to pay permissible bonuses subject to the limitations set forth below.

2. Compliance Monitoring. The Division will monitor each Provider to determine if it has increased CNA base hourly wages by at least the amount of the CNA add-on revenue.

3. Calculation of Recovery Amount. The Division will notify the Division of Medical Assistance to recover any 2001 CNA add-on revenue not spent on CNA wage increases, payroll taxes, and permissible bonuses as set forth below.

a. Calculation of Add-on Revenue. This is the total amount of revenue the facility received during 2001 for the purposes of increasing base wages to CNAs. The Division will multiply the 2001 CNA add-on by Medicaid patient days in 2001 to determine the Medicaid revenue generated by the add-on.

b. Estimated Target Wage Increase. This is the estimated wage increase based on the average hourly CNA wages in the base period, which is the first quarter of 2000. This amount is (1) the product of the Provider's 2001 CNA add-on times its annualized first quarter 2000 Medicaid days divided by (2) the Provider's annualized first quarter 2000 CNA hours.

c. 2001 Average Hourly Wage Increase. This is the total amount of increase in the average hourly wage given as a result of the add-on. This is the difference between (1) the Provider's average hourly wage in the base period (first quarter 2000 CNA wages and payroll taxes divided by the Provider's CNA hours in the first quarter of 2000) and (2) the average hourly wage in the rate period (2001 CNA wages and payroll taxes divided by CNA hours in 2001).

d. Actual Target Wage Increase. This amount is determined by dividing the Provider's 2001 add-on revenue by the Provider's 2001 CNA hours.

e. Test One. The Division will determine the amount that the Provider should have increased wages based on the actual revenue received and the actual hours paid during 2001. To determine the required increase:

1. If 2001 CNA hours are lower than or equal to first quarter annualized 2000 CNA hours, the Division will divide 2001 add-on revenue by 2001 CNA hours;
2. If 2001 CNA hours are greater than first quarter annualized 2000 CNA hours, the Division will divide 2001 add-on revenue by annualized first quarter 2000 CNA hours.

If the Provider's 2001 average hourly wage increase exceeds the applicable amounts, the Provider is not subject to a recovery. If the Provider's 2001 average hourly wage increase is less than these amounts, the Provider will be subject to a recovery unless it qualifies for and has paid a permissible bonus under Test Two.

f. Test Two: Permissible Bonuses. A provider may fail Test One because of variances in Medicaid days or CNA hours. In these cases, a provider may pay unspent funds to the CNAs in the form of a permissible bonus. These permissible bonuses fall into two categories:

1. The Division will permit a Provider to spend up to 10% of the lower of its Estimated or Actual Target Wage Increase as a permissible bonus to account for variances. This bonus amount is calculated as follows: (10% of the target increase * the lower of 2001 CNA hours or 2000 CNA hours).

2. In addition, providers that had fewer CNA hours and/or more Medicaid days in the rate period may spend any additional revenue as a permissible bonus. This creates a situation where the actual target increase is greater than the estimated target increase. The amount of this permissible bonus is determined as follows: ((Actual target increase – estimated target increase) * CNA rate year hours)).

g. The Division will determine whether the Provider has spent the add-on revenue on CNA hourly wage increases, or where applicable, permissible bonuses. The recovery amount will be the difference between the Add-on Revenue received and the total wage increase given, determined as follows:

Revenue received = (per diem add-on * 2001 Medicaid days)

Total increase given =
((rate period average hourly wage – base period average hourly wage) * lower of annualized base period CNA hours or 2001 CNA hours) + permissible bonus (if given)

h. The Provider must repay to the Division of Medical Assistance 150% of the recovery amount. The Division will notify the Division of Medical Assistance of the amount to recover from the Provider.

i. The Division and/or the Division of Medical Assistance may conduct audits to verify amounts reported in the cost reports.

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

Section

6.01: General Provisions

(1) Scope and Effective Date. 114.2 CMR 6.00 governs the payments effective January 1, 2001 for services rendered to Publicly-Aided and Industrial Accident Residents by Nursing Facilities including residents in a Residential Care Unit of a Nursing Facility.

(2) Authority. 114.2 CMR 6.00 is adopted pursuant to M.G.L. c. 118G.

6.02: General Definitions

As used in 114.2 CMR 6.00, unless the context requires otherwise, terms have the following meanings. All defined terms in 114.2 CMR 6.00 are capitalized.

ACE Group. The Audit, Compliance and Evaluation Group of the Division of Health Care Finance and Policy.

Actual Utilization Rate. The occupancy of a Nursing Facility calculated by dividing total Patient Days by Maximum Available Bed Days.

Additions. New Units or enlargements of existing Units which may or may not be accompanied by an increase in Licensed Bed Capacity.

Administrative and General Costs. Administrative and General Costs include the amounts reported in the following accounts: administrator salaries; payroll taxes - administrator; worker's compensation - administrator; group life/health - administrator; administrator pensions; other administrator benefits; clerical,; EDP/payroll/bookkeeping services; administrator-in-training; office supplies; phone; conventions and meetings; help wanted advertisement; licenses and dues, resident-care related; education and training - administration; accounting - other; insurance - malpractice; other operating expenses; realty company variable costs; management company allocated variable costs; and management company allocated fixed costs. For facilities organized as sole proprietors or partnerships and for which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits, administrative and general costs shall include an imputed value of $69,781 to reflect the costs of such services.

Administrator-in-Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR.

Audit. An examination of the Provider's cost report and supporting documentation to evaluate the accuracy of the financial statements and identification of Medicaid patient-related costs.

Building. Building Costs include the direct cost of construction of the structure that houses residents and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures that are made a

permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect's fees and certain legal fees. Building Costs include interest paid during construction to Building Costs but not Mortgage Acquisition Costs.

Capital Costs. Capital Costs include Building Depreciation, Financing Contribution, Building Insurance, Real Estate Taxes, non-income portion of Massachusetts Corp. Excise Taxes, Other Rent and Other Fixed Costs.

Case-Mix Category. One of six categories of resident acuity that represents a range of Management Minutes.

Change of Ownership. A bona fide transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties. A Change of Ownership must be a sale of assets of the Provider rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

Constructed Bed Capacity. A Nursing Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in the Department's regulation 105 CMR 100.020 which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes rooms designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (e.g. drinking water, sprinkler lines, oxygen, electric current) with either outlets or capped lines within the room.

Department. The Massachusetts Department of Public Health.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. A fixed asset, usually moveable, accessory or supplemental to the Building, including such items as beds, tables, and wheelchairs .

Financing Contribution. Payment for the use of necessary capital assets whether internally or externally funded.

Hospital-Based Nursing Facility. A separate Nursing Facility Unit or Units located in a hospital building licensed for both hospital and Nursing Facility services in which the Nursing Facility licensed beds are less than a majority of the facility's total licensed beds and the Nursing Facility patient days are less than a majority of the facility's total patient days. It does not include free-standing Nursing Facilities owned by hospitals.

Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the Provider is in some way better than it was before the renovation. Improvements do not add to or expand the square footage of the Building. An improvement is measured by the Provider's increased productivity, greater capacity or longer life.

Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

Industrial Accident Resident. A person receiving Nursing Facility services for which an employer or an insurer is liable under the workers compensation act, M.G.L. c. 152, et seq.

Land. Land Costs include the purchase price plus the cost of bringing land to a productive use including, but not limited to, commissions to agents, attorneys' fees, demolition of Buildings, clearing and grading the land, constructing access roads, off-site sewer and water lines, and public utility charges necessary to service the land; and land Improvements completed before the purchase. The land must be necessary for the care of Publicly-Aided Residents.

Licensed Bed Capacity. The number of beds for which the Nursing Facility is either licensed by the Department of Public Health pursuant to 105 CMR 100.020, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department. The Department issues a license for a particular level of care.

Major Addition. A newly constructed addition to a Nursing Facility which increases the Licensed Bed Capacity of the facility by 50% or more.

Management Minutes. A method of measuring resident care intensity, or case mix, by discrete care-giving activities or the characteristics of residents found to require a given amount of care.

Management Minutes Questionnaire. A form used to collect resident care information including but not limited to case-mix information as defined by the Division of Medical Assistance.

Massachusetts Corporate Excise Tax. Those taxes which have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Maximum Available Bed Days. The total number of licensed beds for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A Provider's weighted average Licensed Bed Capacity for the calendar year, determined by (1) multiplying Maximum Available Bed Days for each level of care by the number of days in the calendar year for which the Nursing Facility was licensed for each level and (2) adding the Maximum Available Bed Days for each level and (3) dividing the total Maximum Available Bed Days by the number of days in the calendar year.

Mortgage Acquisition Costs. Those costs (such as finder's fees, certain legal fees, and filing fees) that are necessary to obtain Long-Term financing through a mortgage, bond or other Long-Term debt instrument.

New Facility. A Nursing Facility that opens on or after January 1, 2000. A Replacement Facility is not a New Facility.

Nursing Costs. Nursing costs include the 1998 Reported Costs for Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, and the Workers Compensation expense, Payroll Tax expense, and Fringe Benefits, including Pension Expense, associated with those salaries.

Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, s.71; or a Nursing Facility operating under a hospital license issued by the

Department pursuant to M.G.L. c. 111, and certified by the Department for participation in the State Medical Assistance Program. It includes facilities that operate a licensed residential care Unit within the Nursing Facility.

Other Fixed Costs. Other Fixed Costs include Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment, the Non-Income portion of the Massachusetts Corporate Excise tax, Building Insurance, and Rental of Equipment located at the facility.

Other Operating Costs. Other Operating Costs include, but are not limited to the following reported costs: plant, operations and maintenance; dietary; laundry; housekeeping; ward clerks and medical records librarian; medical Director; Advisory Physician; Utilization Review Committee; Employee Physical Exams; Other Physician Services; House Medical Supplies Not Resold; Pharmacy Consultant; Social Service Worker; Indirect Restorative and Recreation Therapy Expense; Other Required Education; Job Related Education; Quality Assurance Professionals; Management Minute Questionnaire Nurses; Staff Development Coordinator; Motor Vehicle Expenses including, but not limited to depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax; and Administrative and General Costs.

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of Patient Days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a Provider reserves a vacant bed for a Publicly-Aided Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the Division of Medical Assistance. It also includes days for which a bed is held vacant and reserved for a non-publicly-aided resident.

Private Nursing Facility. A Nursing Facility that does not have a provider agreement with the Division of Medical Assistance to provide services to publicly-assisted Residents.

Provider. A Nursing Facility providing care to Publicly-Aided Residents or Industrial Accident Residents.

Publicly-Aided Resident. A person for whom care in a Nursing Facility is in whole or in part subsidized by the Commonwealth or a political sub-Division of the Commonwealth. Publicly-Aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Rate Year. The calendar year in which the standard payments are in effect.

Related Party. An individual or organization associated or affiliated with, or which has control of, or is controlled by, the Provider; or is related to the Provider, or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended provided, however, that 10% is the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mother-in-law, brothers-in-law and sisters-in-law.

Replacement Facility. A Nursing Facility licensed prior to January 1, 2000 that replaces its entire building with a newly-constructed facility pursuant to an approved Determination of Need under 105 CMR 100.505(a)(6). A facility that renovates a building previously licensed as a nursing facility is not a Replacement Facility.

Reported Costs. All costs reported in the cost report, less costs adjusted and/or self-disallowed in Schedules 13 and 14 of the 1998 cost reports.

114. 2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to Publicly-Aided Residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department in accordance with 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Residential Care Unit. A Unit within a Nursing Facility which has been licensed by the Department to provide residential care.

Unit. A Unit is an identifiable section of a Nursing Facility such as a wing, floor or ward as defined by the Department in 105 CMR 150.000 (Licensing of Long-Term Care Facilities).

6.03: Nursing

(1) Nursing Standard Payments. New Facilities and Hospital-based Nursing Facilities will be paid at the Nursing Standard Payments. The Nursing Standard Payments are:

Payment Group	Management Minute Range	Standard Payment
H	0 - 30	10.07
JK	30.1 – 110	26.86
LM	110.1 – 170	47.67
NP	170.1 – 225	66.48
RS	225.1 – 270	83.47
T	270.1 and above	101.31

(2) Nursing Transition Payments. All facilities except New Facilities and Hospital-Based Nursing Facilities will be paid Nursing Transition Payments.

(a) Determination of Facility Rates. For each facility, the Division will calculate six case mix adjusted nursing rates.

1. Allowable Nursing Cost per Management Minute. The Division will determine a facility's Allowable Nursing Costs as follows:

a. 1998 Actual Nursing Cost per Management Minute. A facility's Actual Nursing Cost per Management Minute is the sum of its reported Nursing Costs divided by the greater of (1) 96% of the current Licensed Bed Capacity for 1998 times 365 or (2) actual 1998 patient days, divided by the facility's 1998 average Management Minutes.

b. Determination of Nursing Ceiling. The Division will calculate a Nursing Ceiling based upon reported 1998 average nursing cost per management minute as follows:

i. The Division will calculate a nursing per diem for each facility by dividing the facility's claimed 1998 nursing costs by the greater of 1998 patient days or 96% of the Mean Licensed Bed Capacity in 1998 times 365.

ii. The Division will calculate the 1998 average nursing cost per Management Minute for each facility by dividing the 1998 nursing cost per diem by the facility's 1998 average Management Minutes.
iii. The Nursing Ceiling is 110% of the median claimed 1998 average Nursing Cost per Management Minute, or $0.343 per Management Minute.

c. Allowable Nursing Cost per Management Minute. A facility's Allowable Nursing Cost per Management Minute is the lower of its 1998 Actual Nursing Cost per Management Minute or the Nursing Ceiling.

2. Calculation of Six Nursing Per Diem Rates. The Division will multiply the allowable nursing cost per management minute by the facility's average management minutes per case-mix category to obtain a per diem rate for each category. If the facility-specific mean minutes per payment group equals zero, the Division will use the industry median minutes for that category. The Division will apply a Cost Adjustment Factor of 7.59% to the six weighted nursing per diem rates.

(b) Nursing Transition Payments.

1. The Division will calculate weighted rates for each nursing facility using second quarter 2000 case mix data. If 2000 case mix data is not available, the Division will use the best available data.
2. The weighted rate is the sum of the products of (1) 80% of the Standard Payment for each category plus (2) 20% of the Facility Rate for each category times the corresponding case mix proportion.
3. The Nursing Transition Payment for categories JK through T will equal the weighted rates for each category.
4. The Nursing Payment for Payment Group H is the Nursing Standard Payment of $10.07.

6.04: Other Operating Costs.

(1) Other Operating Cost Standard Payments. New Facilities and Hospital-based Nursing Facilities will be paid at the Standard Payments. The Other Operating Cost Standard Payment for each Payment Group is $54.96.

(2) Other Operating Cost Transition Payment. All facilities except New Facilities and Hospital-Based Nursing Facilities will be paid Transition Payments.

(a) Determination of the Allowable Other Operating Costs. The Division will determine the facility's Allowable Other Operating Costs per diem as follows:

1. The Division will subtract the facility's reported 1998 Administrative and General expenses from reported 1998 Other Operating expenses to obtain Net Other Operating Expenses.
2. The facility's Net Other Operating Expenses per day is equal to Net Other Operating Expenses divided by the greater of
   a. 96% of the mean Licensed Bed Capacity in 1998 times 365, or
   b. actual patient days.
3. The facility's Allowable Administrative and General per diem is equal to the lower of
   a. reported 1998 Administrative and General expenses divided by the greater of
      i. 96% of the mean Licensed Bed Capacity in 1998 times 365, or
      ii. actual patient days, or
   b. the Administrative and General ceiling of $11.48 per day.